availability of equipment.

In United Kingdom (UK), the Specialist Registrar trainee are required to perform at least 18 tibial IM nailing over 6 years to fulfil one of the key surgical procedural requirement. Failure to do so would result in delay in completing the training. However, this is not as straight forward as one believes.

Material and method: James Cook University Hospital (JCUH) is a level 1 trauma centre in NE of England. We have looked into the surgical treatment of extra-articular fracture from 2005. There is about 50 extra-articular tibial fractures per year presented to our unit. This is a retrospective review. Patient list is collected from theatre record and radiographs are assessed for the level of tibial injury. The treatment choice is recorded and analysed.

Union rate and follow-up length are also noted.

Results: The usage of IM nail has fallen from 62% to 51% over the years, while tibial locking plate has gone up from 13% to 42%. Another significant change is the drop of external fixator as a first line management technique, which has gone down from 20% to 5%. The increase in plating is particularly seen in the proximal and distal third portion of the tibia.

Conclusion: Our unit has 9 specialist registrars on the trauma rota. On average, each should just have 3 IM nailing performed per year, making the total of 18 over 6 years. In reality, the random fashion of trauma presentation would mean some missing out. If a busy unit could only provide enough opportunity for 1 year quota, a smaller quieter district general hospital is unlikely to do better. Together with the adoption of the 48-h working rule in UK, this could reduce the training opportunity further. The training issue has to be addressed sooner rather than later.

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Is "*Softcast*" (3 M) strong enough for acute potentially unstable paediatric forearm fractures?

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Introduction: After orthopaedic assessment, the vast majority of paediatric forearm fractures are treated using a circumferential splint, with prior manipulation as necessary. Plaster of Paris is often chosen for its ease of application, cost and proven reliability.

Softcast is an attractive alternative, as it provides a comfortable and water-resistant splint that can be removed without a plaster saw. Patient satisfaction has been demonstrated when used to protect buckle fractures, and its cost may be offset by reducing the number and duration of hospital visits. Unreinforced *Softcast* has not, however, been recommended for acute potentially unstable fractures.

Objectives: To establish whether a *Softcast* splint can provide sufficient mechanical stability to control a potentially unstable paediatric forearm fracture, and protect the wearer from further injury.

Methods: A laboratory study was undertaken to compare the bending, kinking and torsion loads withstood by standardised POP, *Softcast* and reinforced *Softcast* splints at clinically relevant endpoints.

Results: The load at clinical failure of a 6-wrap *Softcast* forearm splint was 504 N in bending, 202N in kinking, and 11 Nm in torsion (equalling 30.4%, 26% and 42.2% of the equivalent values for a circumferential 4-wrap POP). The 6-wrap *Softcast* was however stronger in all modes than a fibreglass-reinforced *Softcast* splint, body weight in many paediatric patients.

Softcast demonstrated complete recovery of its original shape on unloading, where as POP was permanently deformed. POP splints were 4% heavier than 6-wrap *Softcast*.

Conclusion: A 6-wrap *Softcast* splint provides adequate mechanical stability and protection for paediatric patients up to 20 kg, not engaged in high-risk activities. The primary risk is not of fracture angulation and loss of position, but temporary indentation of the splint against a point or edge, causing discomfort or pain. Considering its ease of removal, *Softcast* may be preferable for younger paediatric patients.

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Preparation and outcome of the emergency medical services in the hospital and prehospital field during the EUFA Euro 2008 in Bern Switzerland

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The 2008 European Football Championship 2008 (Euro 08) has been the largest sporting event ever organised in Switzerland.

One Mio. visitors came to the city of Berne during the event and the local airport in Bern/Belp registered 261 extra flights. Per game 33,000 fans in the stadium und 100,000 fans in the public viewing zones were watching. football

The ambulance corps and the Department of Emergency Medicine (ED) at Inselspital, University Hospital Berne, were responsible for basic medical care and emergency medicine management. Injuries and illnesses were analysed by a standardized score (NACA-score). The preparation strategy as well as costs and patient numbers are presented in detail.

A total of 30 additional ambulance cars were used, 4723 additional working days (one third medical professionals) cumulated, 662 ambulance calls were registered and 240 persons needed medical care(62% Swiss, 28% Dutch, 10% other nationals). Among those 51 were treated in one of the four city hospitals. No injuries with NACA VI and VII occurred (NACA I: 4, NACA II: 17, NACA III: 16, NACA IV: 10 and NACA V: 4 patients). All together the city of Bern came up for 112,761.15 Euros extra medical care costs at the Inselspital Bern. The largest amount was spent for security measures (50,300 Euros) and medical staff (medical doctors 22,600 Euros, nurses 29,000 Euros). Because of the poor weather and the fans' exemplary behaviour, the course of events was rather peaceful.

Our presentation will show the efforts, costs and benefits of an urban ED/EMS service preparing for such an event and will present lessons learnt for the future.

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